# PROMISING PRACTICES IN HOME AND COMMUNITY-BASED SERVICES

***California – Village Integrated Service Agency***

## Issue: Comprehensive, Individualized Services for People with Serious Mental Illnesses Through a Single Provider


### Summary

Village Integrated Service Agency, a program of the Mental Health Association in Los Angeles County, integrates all components of mental health care including treatment, rehabilitation, family and community support, and self-help to provide the services that people with mental illness need to achieve self-sufficiency. It tailors services to each individual's mental health needs. It has become a national model and a training ground to help others replicate its approach.


### Introduction

The Village Integrated Service Agency, a program of the Mental Health Association in Los Angeles County (MHA Village), provides coordinated, comprehensive services for people with mental illness. Available services are determined by the needs and expressed goals of people who receive the services (which MHA Village calls "members"). MHA Village helps each person develop and implement a customized service plan by selecting from a menu of psychiatric, employment, housing, health, financial and recreation options. Members' plans may include self-help, peer/family support, and community involvement.

**MHA Village helps each person develop a customized service plan.**

This report briefly describes MHA Village, its origins, and evidence of its effectiveness in helping people with mental illness live independently. This report is based on interviews with MHA Village staff and documents from MHA Village, including information from an independent evaluation of the program by the Lewin-VHI, Inc.

### Background

Located in Long Beach, California, the MHA Village began in April 1990 as a pilot funded by the California Department of Mental Health. The pilot designed and tested an innovative delivery system that provided all mental health-related services. In creating the Village, MHA designed a comprehensive program with a multidisciplinary team concept, a "menu approach" to services, and personal service plans.

After its pilot phase, the MHA Village became a permanent program, with a shift in funding from the state to the county level. In fiscal year 1996-97, the MHA Village restructured its financing system to improve its cost-effectiveness and expanded from its original 113 members to serve 276 adults with serious mental illness.

### Intervention

MHA Village's philosophy and practices differ from many programs for people with mental illness in several ways. MHA Village establishes collaborative relationships between staff and members. The expert to patient role is de-emphasized; members are equal partners in determining the services they receive. The MHA Village encourages continued growth and development for members, as opposed to a common goal of simply preventing negative outcomes. The program tries to create a high risk/high support environment that promotes hope and the recovery process. Staff achieve this environment by establishing adult-to-adult interactions with members, providing supportive

services in whatever setting the member chooses, encouraging members to try new things, and helping members to overcome a common fear of failure.

MHA Village services are built around a multidisciplinary team concept. Each of the Village's three teams is made up of a team leader, five personal service coordinators (who are a mixture of licensed social workers, nurses, psychiatric technicians, and a variety of unlicensed staff), and a 30-hour-per-week psychiatrist. The personal service coordinators help members identify and pursue their goals by providing services directly and by helping members to access outside services. Resource specialists in employment, community integration, money management and substance abuse complement the teams.

MHA Village also has designed an innovative model for blending fiscal and clinical responsibility. Each of the Village's service teams has the authority to decide how funds are spent for the people the team supports. Psychosocial rehabilitation and community integration are at the center of the Village's philosophy and its integrated services. The service teams reflect these values and goals by allocating more resources to employment and community support activities and fewer resources to clinical treatment and hospital services.

MHA Village earns about 40% of its revenue by billing Medicaid under the state plan option for rehabilitative services. Los Angeles County provides additional funds to MHA Village for each member, depending on how much money the county spent on that member in the year prior to enrollment. If the county spent from $10,000 to $80,000 on a member in the year before enrollment, the person is considered a "high utilizer" and MHA Village may collect up to $18,500 per year to serve that person. If the County spent between $2,000 and $9,999 in the year before enrollment, the person is considered a "moderate utilizer" and MHA Village may collect up to $6,500 per year for his or her services. Currently, the Village serves 138 "high utilizers" and 138 "moderate utilizers."

## Implementation

MHA Village staff report the greatest challenge in implementing the MHA Village was the extreme "culture shift" required of both staff and members. It was difficult finding staff trained in the principles of assertive community treatment and psychosocial rehabilitation – the two approaches that form the foundation of the Village's service philosophy. Management had to invest and continues to invest significant resources into providing training on these models as well as on such topics as working as a team and focusing on consumer's strengths when providing case management.

Similarly, many members who previously had been treated primarily in institutional and day treatment settings found it difficult when their personal service coordinator first addressed their "non-illness-based" goals, such as getting a job, finding a boyfriend or girlfriend, or moving into their own apartment. Some members found it frightening to take responsibility for their own achievements and failures. But over time, both members and staff have embraced this culture and it has enhanced feelings of empowerment for both groups.

**Service coordinators help people identify and pursue quality of life goals.**

MHA has experience informing other communities about the MHA Village model and helping them to make the "culture shift". In 1991, MHA launched its training and consultation services in order to promote its integrated service model. Since that time, hundreds of groups from California, other states, and foreign countries – including system planners, service providers, people with mental illness and their families – have received training and consultation regarding the MHA Village model. Over the past five years, the Village model has been replicated in communities across the United States. The model has been adapted to serve different subgroups of people with mental illness (e.g.,

**MHA Village spends fewer dollars on residential services.**

homeless people, incarcerated people, transition age youth).

## Impact

As mandated by its authorizing legislation, Lewin-VHI, Inc., evaluated MHA Village for the three-year pilot period (1990-1993). Lewin compared MHA Village members to a randomly selected comparison group receiving usual treatment services. In its internal evaluation for the same time period, MHA Village measured members' increases in employment, independent living, social involvement, and decreases in the rates of hospitalization and homelessness.

Over the three-year study period, the average annual costs for hospital care for Village members was one-third the average cost for the comparison group, although there was no significant difference between the percentages of members who used inpatient services. One factor in the reduced hospitalization costs was that Village psychiatrists had hospital admitting and discharging privileges and were able to provide greater continuity of care.

MHA Village members were more likely to live in their own home or with their family and more likely to work than people in the comparison group. By the third year, 89 percent of Village members were living independently or with their family and only 11 percent were in institutional care (e.g., board and cares, institutions for mental diseases), down from 16 percent when the study was begun. No Village members were homeless. Over the three-year period, 72.6 percent of Village members tried paid employment compared with 14.6 percent of the comparison group.

Since the original evaluation, MHA Village implemented a computerized outcomes evaluation system. Data from this system indicates that members admitted from July 1996 through April 1999 have experienced a 57 percent increase in independent living, a 78 percent reduction in homelessness, a 93 percent reduction in state hospital usage, and an 80 percent reduction in the use of institutions for mental disease. MHA Village spends only 15 percent of its funds on hospital, acute residential, or other 24-hour care programs, which generally are the most expensive services. The statewide average for California's public system of services for people with serious mental illness is 45 percent.

## Contact Information

For more information about the MHA Village, please contact Martha Long at 562-437-6717 Ext. 252 or marthalong@village-isa.org. Information about the Village is available on the Internet at http://www.village-isa.org

**Some Discussion Questions:**

**Can the culture shift achieved at MHA Village be achieved consistently without integrated service delivery?**

**How can this model be adapted to rural areas where there are fewer people qualified for the multidisciplinary teams?**

This report was written by Amy Leventhal Stern, Ph.D. It is one of a series of reports by The MEDSTAT Group for the U.S. Centers for Medicare & Medicaid Services (CMS) highlighting promising practices in home and community-based services. The entire series will be available online at CMS' web site, http://www.cms.gov. This report is intended to share information about different approaches to offering home and community-based services. This report is not an endorsement of any practice.